78371

EXAMINATION & INITIAL LICENSURE APPLICATION

APPLICATION SHOULD BE TYPED — APPLICATION FEES ARE NON-REFUNDABLE

CHECK METHOD OF APPLICATION, IF BY EXAM INDICATE TYPE)

- ☐ EXAMINATION (application fee $410, background check $43) Total $453
- ☐ C-SPEX (application fee $410, background check $43) Total $453
- ☐ FIFTH PATHWAY (application fee$410, background check $43) Total $453
- ☒ ENDORSEMENT (application fee $460, background check $43) Total $503
- ☐ PUBLIC HEALTH CERTIFICATE (application fee $210, background check $43) Total $253
- ☐ PUBLIC PSYCHIATRY CERTIFICATE (application fee $210 background check $43) Total $253

SEP 18 00

Received Date : 09/20/2000
Deposit Date : 09/20/2000
Deposit # : 167527
Batch Number : 001626
Validation # : 900020574
Check Amount : $503.00
PRO CDE : 1501
REVENUE RECEIPT VALIDATION AREA

RECEIVED
SEP 2 0 2000
BOARD OF MEDICINE

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian __ Black __ Hispanic __ Asian X Native American __ Other __
SEX: Male __ Female __

CATEGORY: _____
CANDIDATE # _____

EXAM SITE: _____
EXAM DATE: _____
EXAM CODE: _____

DOH/ME/031/1-90,
Rev 07/94; 1/95; 10/97; 2/99; 8/99

2. SOCIAL SECURITY NUMBER: [redacted]

3a. CURRENT NAME: Samuel (Last) Milroy (First) Jeevananthan (Middle) (Suffix, if applicable)

b. Have you ever changed your name through marriage or through action of a court? YES ☐ NO ☒

If "yes", list name(s) (Last, First, Middle, Suffix, and Date(s) of changes)

c. Have you ever been known by any other name (aliases)? YES ☐ NO ☒

If "yes", list name(s) (Last, First, Middle, and Suffix)

4a. MAILING ADDRESS (where you receive mail):

6571 Estate View Dr S. (Street and number or PO Box) Blacklick, OHIO 43004 (City) (State or Province) (Zip or Postal Code) (Country)

b. PRIMARY PRACTICE/PHYSICAL ADDRESS (where you can be located-No P.O. Box):

6571 Estate View Dr. S. (Street and number) Blacklick, OHIO 43004 (City) (State or Province) (Zip or Postal Code) (Country)

c. NAME OF PRACTICE: Resident PGY-4

d. FAX NUMBER: _____ (Area Code and Number)

e. DAYTIME TELEPHONE: 614-856-9577 (Area Code and Number)

f. E-MAIL ADDRESS: Doctor9001@Aol.com

BAR CODE SPACE

5. OTHER PRACTICE LOCATION(S)

(Practice Name)	(Street and Number)	(City)	(State or Province)	(Zip or Postal Code)
(Practice Name)	(Street and Number)	(City)	(State or Province)	(Zip or Postal Code)
(Practice Name)	(Street and Number)	(City)	(State or Province)	(Zip or Postal Code)

6. PERSONAL DATA

HEIGHT: 5'7 WEIGHT: 142

COLOR OF EYES: Brown COLOR OF HAIR: Black

PLACE OF BIRTH: Jaffna, Sri Lanka (City) (State/Province) (Country) DATE OF BIRTH: June 6, 1971 (Month) (Day) (Year)

7a. If you were not born in the United States, are you a citizen of the U.S.? YES [X] NO [ ]

b. If you are a Naturalized citizen please provide date and place of Naturalization:

1/10/1978 (Month) (Day) (Year) & Columbus, Ohio (Place)

c. If you are not an U.S. citizen, please provide alien number: _____

8a. Have you ever been in the United States Military and/or Public Health Service? YES [ ] NO [X]

If "yes" list branch of service, rank, dates of service (Enclose copy of discharge form).

b. Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States? YES [ ] NO [X]

If "yes" explain on a separate sheet, providing accurate details.

9. List the year and state/province/country where you legally began to practice.

Resident PGY-4 (Year) OHIO 1998 License (State/Province/Country)

10. Do you hold or have you ever held a Chiropractic/Medical/Osteopathic/Podiatric license or any other profession in any U.S. State or territory, or foreign country? YES [X] NO [ ]

Ohio 1998 #35-075146-S MD

If "yes", state(s)/province(s), type/title of license(s), license number(s)

If "yes", list states and dates of issuance (month and year).

11. Doctor of Chiropractic/Medicine/Osteopathic/Podiatric/professional degree was obtained from: Meharry Medical College 1005 DB Todd Blvd Nashville,TN 3720[illegible] (Name of School/Institution) (Address)

MD (Degree Title) on May 17, 1997 (Month) (Day) (Year)

12. UNDERGRADUATE/GRADUATE/CHIROPRACTIC/MEDICAL/OSTEOPATHIC/PODIATRIC/PROFESSIONAL EDUCATION: e.g. JD, Ed.D., Ph.D., RN, PA, MD, DO, DDS, DC, DPM, etc. - Starting with undergraduate degree, **list all** schools, colleges and universities attended, whether completed or not, in chronological order.

NAME COLLEGE/UNIVERSITY ADDRESS/CITY/STATE/COUNTRY	DOMICILE ADDRESS/CITY/STATE/ COUNTRY	MAJOR/MINOR COURSE OF STUDY	DID YOU GRADUATE/ DATE	FROM: MM/DD/YY	TO: MM/DD/YY	TYPE OF DEGREE RECEIVED	HEALTH RELATED	
							YES	NO
Capital University	Columbus OH	-	No	9/87	6/93	-		x
Ohio State Univ	Columbus OH	Finance	Yes	9/88	6/93	BS/BA		X
Meharry Med College	Nashville, TN	MD	Yes	7/93	5/97	MD	X	

13. CHIROPRACTIC/MEDICAL/OSTEOPATHIC/PODIATRIC/PROFESSIONAL EDUCATION: e.g. JD, Ed.D., Ph.D., RN, PA, MD, DO, DDS, DC, DPM, etc.

a. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college, or university? YES ☐ NO ☒

If "yes", explain on a separate sheet providing accurate details.

14a. List in chronological order from date of graduation from Chiropractic/Medical/Osteopathic/Podiatric/Professional school all professional/postgraduate training (Internship/Residency/Fellowship) to the present.

PROFESSIONAL/POSTGRADUATE TRAINING NAME PROGRAM (INTERNSHIP/RESIDENCY/FELLOWSHIP/OTHER)	PROGRAMS FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	SPECIALTY AREA	MONTH/YEAR FROM		MONTH/YEAR TO		CREDIT RECEIVED YES	CREDIT RECEIVED NO
Ohio State University	Dept of OB/GYN 5th Fl Means Hall 1670 Upham Dr Columbus, OH 43210	OB/GYN	6	97	6	01	6/01	

14b. Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave, temporarily or permanently, or otherwise acted against by a Chiropractic/Medical/Osteopathic/Podiatric /Professional training program prior to completion of training? YES ☐ NO ☒

If "yes", list below and see instructions for required documentation

14c. List in chronological order from date of graduation from Chiropractic/Medical/Osteopathic/Podiatric/Professional school all professional/postgraduate training (Internship/Residency/Fellowship) **discipline** to the present.

PROFESSIONAL/POSTGRADUATE TRAINING NAME PROGRAM (INTERNSHIP/RESIDENCY/FELLOWSHIP/OTHER)	POSTGRADUATE TRAINING INSTITUTION/HOSPITAL	PROGRAMS FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	MONTH/YEAR	
			FROM	TO
None				

15. PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time from date of matriculation into (Chiropractic/Medical/Osteopathic/ Podiatric or Board applicable title, e.g.) school.

TYPE OF PRACTICE AND EMPLOYMENT OR NON-EMPLOYMENT	NAME AND ADDRESS OF PRACTICE SETTING (STREET NUMBER AND NAME, ADDRESS, CITY, STATE, TERRITORY, COUNTRY) OF NON-EMPLOYMENT, EMPLOYMENT AND/OR PRACTICE SETTING	MONTH/YEAR			
		FROM		TO	
None					

16. STAFF PRIVILEGES -

a. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? YES ☐ NO ☒

If "yes", complete section 16b.

16b. List any hospital/health institution/clinic or medical facility where you have staff privileges (Do Not List Training Privileges).

NAME OF HOSPITAL/INSTITUTION/CLINIC/ FACILITY	NAME OF CHIEF OF STAFF	FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	TYPE OF PRIVILEGES	MONTH/YEAR FROM	MONTH/YEAR TO

c. Within the most recent 10 years have you had responsibility for graduate medical education? YES ☐ NO ☒

d. Do you currently hold a faculty appointment at a Chiropractic/Medical/Osteopathic/ Podiatric/health-related institution of higher learning? YES ☐ NO ☒

If "yes", complete section 16e.

16e. List any hospital/health institution/clinic or medical facility where you have faculty appointment.

NAME OF INSTITUTION	FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	TITLE OF APPOINTMENT

f. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any hospital, health maintenance organization, health institution, ambulatory surgical center, nursing home, clinic or medical facility? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

INSTITUTION NAME	DATE MM/DD/YY	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL YES	UNDER APPEAL NO

16g. Have you ever been asked, or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action or during any pending investigations into your practice? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

NAME AND ADDRESS OF HOSPITAL/INSTITUTION/CLINIC/FACILITY	DATE MM/DD/YY	DESCRIPTION OF VIOLATION OR INVESTIGATION	REASONS LISTED FOR RESIGNATION	ALLOWED TO RETURN YES	ALLOWED TO RETURN NO

h. Have you ever had any medical staff privileges restricted or not renewed by any hospital, institution, clinic or medical facility in lieu of disciplinary action? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

NAME AND ADDRESS OF HOSPITAL/INSTITUTION/CLINIC/FACILITY	DATE MM/DD/YY	DESCRIPTION OF CURCUMSTANCES	DESCRIPTION OF ACTION

17. LIST ALL CHIROPRACTIC/MEDICAL/OSTEOPATHIC/PODIATRIC/PROFESSIONAL SOCIETY OR ASSOCIATION MEMBERSHIPS:

NAME OF PROFESSIONAL SOCIETY OR ASSOCIATION MEMBERSHIP	FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	DATES OF AFFILIATION FROM	DATES OF AFFILIATION TO
American Colleger of OB/GYN	409 12th St, SW Washington DC 20024	1998	Now

a. Have you ever had an application for membership denied by a Chiropractic/Medical/Osteopathic/Podiatric/professional society or association membership? YES ☐ NO ☒

b. Have you ever had a Chiropractic/Medical/Osteopathic/Podiatric/professional society or association membership suspended? YES ☐ NO ☒

c. Have you ever been notified to appear before a Chiropractic/Medical/Osteopathic/Podiatric/professional society or association in regard to charges/complaints filed against you? YES ☐ NO ☒

If "yes" complete section 17d and see instructions for required documentation.

17d. LIST ALL CHIROPRACTIC/MEDICAL/OSTEOPATHIC/PODIATRIC/PROFESSIONAL SOCIETY OR ASSOCIATION MEMBERSHIPS SANCTIONS:

NAME OF PROFESSIONAL SOCIETY OR ASSOCIATION MEMBERSHIP	FULL MAILING ADDRESS (FLOOR, ROOM, BOX, STREET NUMBER, CITY, STATE, COUNTRY, ZIP)	DATE MM/DD/YY

18. SPECIALTY BOARD CERTIFICATION:

a. Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, American Chiropractic Association, International Chiropractors Association, American Osteopathic Association, or other similar national organization or from any specialty board recognized by the Florida board regulating your profession? YES ☐ NO ☒

If "yes", complete section 18b and enclose a copy of each board certification or letter of verification.

b. LIST ALL SPECIALTY BOARD CERTIFICATIONS:

BOARD NAME	CERTIFICATION/SPECIALTY/SUBSPECIALTY	DATE OF CERTIFICATION & RECERTIFICATION

c. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? YES ☐ NO ☒

If "yes", explain on a separate sheet, providing accurate details.

d. Have you ever had any sanctions taken against you by a specialty board recognized by the American Board of Medical Specialties, American Chiropractic Association, International Chiropractors Association, American Osteopathic Association or other similar national organization or from any specialty board recognized by the Florida board regulating your profession? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

SPECIALTY BOARD NAME	DATE MM/DD/YY	DESCRIPTION OF CURCUMSTANCES	DESCRIPTION OF ACTION	UNDER APPPEAL YES	UNDER APPPEAL NO

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO.

19. Have you had any application for professional license or any application to practice Chiropractic/Medical/Osteopathic/Podiatric denied, by any state board or other governmental agency of any state or country? YES ☐ NO ☒

20. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Chiropractic/Medical/Osteopathic/Podiatric practice act, unprofessional or unethical conduct? YES ☐ NO ☒

21. Have you ever had any professional license or license to practice Chiropractic/Medical/Osteopathic/Podiatric revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? YES ☐ NO ☒

If "yes" for questions 19-21, list below and see instructions for required documentation.

NAME OF AGENCY	DATE MM/DD/YY	DESCRIPTION OF CURCUMSTANCES	DESCRIPTION OF ACTION	UNDER APPEAL YES	UNDER APPEAL NO

22. Have you ever been convicted or found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty to Nolo Contendere to a criminal misdemeanor or felony in any jurisdiction? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

DESCRIPTION OF OFFENSE	DATE MM/DD/YY	JURISDICTION	DESCRIPTION OF ACTION	UNDER APPEAL YES	UNDER APPEAL NO

23. In addition to question 22 regardless of adjudication have you ever been convicted of, or pled guilty to Nolo Contendere, entered into any plea, negotiated plea, bargain, or settlement to, any charges of any violations of Federal, State, Local statute, regulation or ordinance? If "yes", list below and see instructions for required documentation. YES ☐ NO ☒

DESCRIPTION OF OFFENSE	DATE MM/DD/YY	JURISDICTION	DESCRIPTION OF ACTION	UNDER APPEAL YES	UNDER APPEAL NO

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO.

24. Have any actions in bankruptcy court or any civil judgments ever been entered against you arising from your professional activity? YES ☐ NO ☒

If "yes", list below and see instructions for required documentation.

DATE OF OCCURANCE MM/DD/YY	LOCATION	CLAIMANT	AMOUNT	DATE OF FINAL DISPOSITION MM/DD/YY

25. Have you ever been the subject of a lawsuit or insurance claim, settled or pending, regardless of the result arising from your professional activity and brought against you or any partner, associate, or employee? YES ☐ NO ☒

If "yes", list below and see instructions for required documentation.

DATE OF OCCURANCE MM/DD/YY	LOCATION	CLAIMANT	AMOUNT	DATE OF FINAL DISPOSITION MM/DD/YY

26. Have you ever had employment terminated for cause? YES ☐ NO ☒

27. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? YES ☐ NO ☒

28. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? YES ☐ NO ☒

29. Have you ever been made an offer to compromise or entered into any other arrangement for other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? YES ☐ NO ☒

30. Have you ever been denied, or surrendered, a DEA Registration? YES ☐ NO ☒

31. Have you ever been required by any licensing jurisdiction to enter into an impaired practitioner or recovery program?

32. Are you now or have you ever been enrolled in or participated in any drug, alcohol or impaired practitioner or recovery program?

[redacted]

ALL AFFIRMATIVE ANSWERS MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO.

33. During the course of your Chiropractic/Medical/Osteopathic/Podiatric education and training or practice experience, have you undergone counseling, therapy, or treatment for any condition that impacted your ability to function in any educational or practice setting?

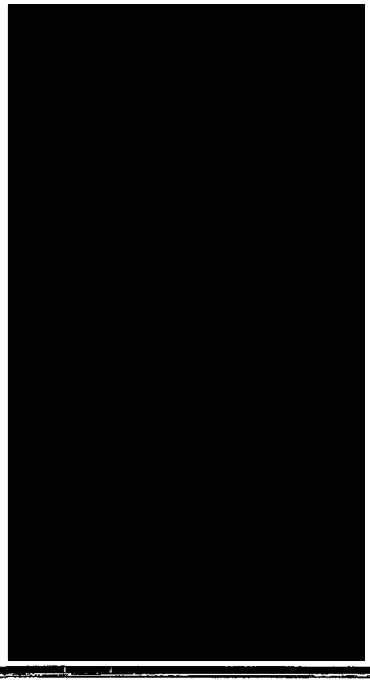
34. Have you been admitted to or confined within a hospital or institution for the purpose of obtaining treatment or therapy for any condition of any kind during the course of you medical education, training, or practice experience?

35. Have you ever declined to follow the recommendation or request of a physician, counselor, employer, supervisor, training program director or representative that you enter therapy or treatment for any condition?

36. Do you have any condition that might affect your ability to practice your profession or that might affect your ability to safely perform any procedures or tasks that are within the scope of your practice?

37. Are you now or have you ever been addicted to narcotics, drugs, hallucinogenic, depressant or stimulatory substances or intoxicants?

38. Have you ever voluntarily or otherwise been a patient in an institution for treatment of any condition, including drug addiction/abuse, or excessive use of alcohol?



39. Board Unique Questions: If "yes" explain on a separate sheet, providing accurate details.

a.	Did you receive advanced standing into medical school?	YES ☐	NO ☒
b.	Did you take a leave of absence during medical school?	YES ☐	NO ☒
c.	Were you required to repeat any of your medical education?	YES ☐	NO ☒

INTERNATIONAL MEDICAL GRADUATES PROVIDE THE FOLLOWING:

CLERKSHIP(S) - Be specific: Account for each clerkship. List specific date(s), type of rotation, and name and location of hospital, institution or individual where clerkship was performed or supervised. List affiliate University/College.

MEDICAL SCHOOL ROTATION; INSTITUTION/INDIVIDUAL ADDRESS/CITY/STATE/COUNTRY	AFFILIATE PROGRAM	DOMICILE WHERE LIVED ADDRESS/CITY/STATE/COUNTRY	MONTH/YEAR FROM		TO	

ECFMG standard certificate or results letter number _____
(List number and date of issuance.)

40. STATEMENT OF FINANCIAL RESPONSIBILITY (Allopathic activation part of application)

41. LIABILITY CLAIMS

(Allopathic, Osteopathic and Podiatric Physicians Only)

A. Are you covered by an insurer required to report pursuant to s. 627.912 F.S.?	YES ☐	NO ☒
B. Have you been insured continuously during the last ten years?	YES ☐	NO ☒
If you answered no to either A. or B. above, you must complete the following:		
Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000?	YES ☐	NO ☒
If "Yes" complete and attach a copy of EXHIBIT 1 for each occurrence. NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire to satisfy this reporting requirement.		

(Chiropractic Physicians Only)

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000?	YES ☐	NO ☐
If "Yes" complete and attach a copy of EXHIBIT 1 for each occurrence. NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire to satisfy this reporting requirement.		

42. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years:

TITLE	PUBLICATION	DATE
1.		
2.		
3.		
4.		

B. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? YES ☐ NO ☒

TYPE OF PROVIDER
1.
2.
3.
4.

C. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS, OR AWARDS:

COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	Mentor Program Ohio State University
2.	
3.	
4.	

D. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice.

1.

2.

3.

4.

E. COMMITTEES/MEMBERSHIPS: Indicate any committees on which you serve for any health entity with which you are affiliated.

NAME OF ORGANIZATION
1.
2.
3.
4.

43. AFFIDAVIT OF APPLICANT:

I, Milroy J. Samuel, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents, and that the attached photograph is a true likeness of myself. I hereby authorize all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Chiropractic/Medicine/Osteopathic/Podiatric any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Chiropractic/Medicine/Osteopathic/ Podiatric/surgery in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

June 2001

(specification of date, event or condition upon which this consent expires)

(Signature of Applicant) 8/31/00 (Date)

The foregoing instrument was acknowledged before me this 31 day of August, 19 2000, by Milroy Samuel, who is personally known to me or who has produced Drivers License as identification and (did)/did not take an oath.

Signature of Notary Commission No. _____

My Commission Expires:

Jasmine Sornabala

Name of Notary Typed, Printed or Stamped

SEAL

NOTARIAL SEAL STATE OF OHIO

JASMINE SORNABALA
Attorney at Law
My commission never expires
O.R.C. Section 147.03